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Citation: Lonbay, Sarah and Brandon, Toby (2017) Renegotiating Power in Adult Safeguarding: The Role of Advocacy. The Journal of Adult Protection, 19 (2). pp. 78-91. ISSN 1466-8203

Published by: Emerald

URL: <http://dx.doi.org/10.1108/JAP-09-2016-0023> <<http://dx.doi.org/10.1108/JAP-09-2016-0023>>

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Renegotiating Power in Adult Safeguarding: The Role of Advocacy

Journal:	<i>The Journal of Adult Protection</i>
Manuscript ID	JAP-09-2016-0023.R2
Manuscript Type:	Research Paper
Keywords:	Advocacy, Older people, Safeguarding, empowerment, power, social work

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Empowerment and Proportionality: Advocacy in Adult Safeguarding

Abstract

Purpose:

The increased involvement of adults at risk in the safeguarding process has become a prominent issue within English safeguarding policy. However, there is evidence to suggest that actual levels of involvement are still low. This paper presents findings from a PhD study in relation to the benefits of advocacy in supporting this involvement in adult safeguarding for older people.

Methodology:

Participants in the study included advocates and social workers who had experience of working with older people through the safeguarding process within two North East England local authorities. A critical realist approach through in-depth interviews was taken with all the participants.

Findings:

The research findings in relation to the benefits of advocacy in supporting older people going through safeguarding processes are reported. The practical limitations and factors which help and hinder advocacy support within the process are also considered.

Research limitations:

A key limitation of this research is that it did not include older people who had been through safeguarding amongst the participants.

Implications:

Key implications for practice and policy are discussed.

Originality:

The overall aim of the research was to generate greater knowledge and understanding of the involvement of older people in safeguarding and to identify and develop indicators for best practice in this area.

Value:

A key area highlighted by the research was the benefits of advocacy provision within adult safeguarding.

Keywords: advocacy, advocates, adult safeguarding, older people and social work

Introduction

The involvement of adults at risk within safeguarding procedures has increasingly become a focus within English safeguarding policy since the publication of No Secrets (DH, 2000). This involvement is associated with the personalisation agenda which promotes the importance of offering service users choice and control (Carr, 2012). However, the 'top-down' approach of this agenda has been criticised by some for its assumption that such autonomy is equally accessible to all. Ellis & Preston-Shoot (2012, p. 168), for example, draw attention to the "controlling" of information as a "means of enacting stereotyped judgements about capacity in order to manage people's access to direct payment". Furthermore, those who may be structurally or systemically excluded from accessing their rights as citizens within a political climate of neoliberalism may struggle to access their rights to direct their own care and support needs (Lloyd, 2010; Stewart, 2011). Within an older population this applies particularly to those who may lack capacity to make some decisions around their care, although it may equally apply to those who do not have the confidence or the knowledge to be able to do so (AUTHOR, XXXX). These people in particular may benefit from advocacy support in bridging health and social care services. Advocacy at its core is about engaging with people and helping them to increase "their sense of power [...] to feel more confident, to become more assertive and gain increased choices" (AUTHOR, XXXX). However, within the remit of adult safeguarding, there is some evidence to suggest that advocacy involvement is limited (Irvine et al., 2013; Manthorpe & Martineau, 2010). Advocacy itself is contested in terms of its definition, practice, and potential for positive outcomes. Forbat & Atkinson (2005), for example, highlight the lack of consensus around both its meaning and effectiveness. Advocacy has a tendency to be misunderstood as purely a complaints procedure or as a distinct role that professionals such as social workers can pick up in addition to their existing work (AUTHOR, XXXX). This potential for misunderstanding the role of advocacy has been noted in relation to adult safeguarding (Redley et al., 2011).

There is limited research exploring the involvement of adults at risk within adult safeguarding, but where research has considered this area there is consensus that levels of

involvement are low (Corkhill & Walker, 2010; Jeary, 2004; Wallcraft & Sweeney, 2011; Wallcraft, 2012). Wallcraft and Sweeney (2011) identified a number of barriers to involvement in adult safeguarding processes. These included difficulties in conceptualising risk, exclusion of some groups due to being seen as “lacking value”, and unhelpful procedures for investigating abuse (2011, p.19). They also identified that advocacy could assist in enabling adults at risk to be involved in safeguarding processes (Wallcraft and Sweeney, 2011; Wallcraft, 2012).

This paper presents findings from a PhD study (undertaken at xxxx) which explored the involvement of older people within adult safeguarding. Older people were the focus of this research because they are highly represented within adult abuse and neglect prevalence figures (NHS Information Centre, 2014) and to reduce the remit of the research in order to allow for a more in depth exploration. This paper is specifically concerned with the ways in which advocates help facilitate the involvement of older people within adult safeguarding, as well highlighting factors which either support or inhibit their work.

Policy Framework

The Care Act (2014) replaced previous adult safeguarding policy and placed this area of work on a statutory footing. A key emphasis throughout the development of safeguarding policy has been that of multi-agency working, reflected in the statutory duty for every local authority to establish a Safeguarding Adults Board (SAB) (a multi-agency committee which oversees adult safeguarding in the local area). The Care and Support Statutory Guidance (CSSG) (DH, 2014) which accompanied the legislation defines adult safeguarding as:

Protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action
(DH 2014, p.1)

Adults at risk are described within adult safeguarding policy as those who are “unable to protect [themselves] against [...] abuse or neglect or the risk of it” as a result of their “needs for care and support” (Care Act 2014, Section 42). The Care Act (2014) also incorporates six key principles:

1. Empowerment – Personalisation and the presumption of person-led decisions and informed consent.
2. Prevention – It is better to take action before harm occurs.
3. Proportionality – Proportionate and least intrusive response appropriate to the risk presented.
4. Protection – Support and representation for those in greatest need.
5. Partnership – Local solutions through services working with their communities. Communities having a part to play in preventing, detecting and reporting neglect and abuse.
6. Accountability – Accountability and transparency in delivering safeguarding.

(DH 2014)

Safeguarding is, in reflection of these principles, comparable to advocacy as it shifts its practice from a process led approach to a more person centered approach, which focuses on the adult at risk’s desired outcomes. This approach was strongly influenced by the ‘Making Safeguarding Personal’ (MSP) work which has been incorporated into the CSSG (DH 2014). The MSP guidance states the need to review how advocacy is provisioned within adult safeguarding, as well as highlighting the usefulness of advocacy in “situations where people have capacity as well as where they lack capacity” (Lawson et al. 2014, p.11).

The Care Act (2014) highlights the importance of empowerment and placing the individual at the centre of adult safeguarding processes and associated decision making. There is an established need for this focus with evidence (gathered prior to the implementation of the Care Act) suggesting that older people are often not involved within adult safeguarding processes (Wallcraft & Sweeney, 2011). The review of No Secrets, the seminal policy document (DH, 2009) also found that people often experience protection at the expense of self-determination, further underscoring the importance of proportionality and empowerment.

Advocacy support is provisioned under the Mental Capacity Act (2005). This statute gives a power to local authorities to appoint an Independent Mental Capacity Advocate (IMCA) in cases where the person lacks capacity to make key decisions (regardless of whether there is a family member or friend supporting them). However, research which has examined IMCA provision within adult safeguarding processes has found that it is often limited (Irvine et al., 2013). In 2013/2014 there were a reported 88,260 safeguarding referrals concluded, of which 28% lacked capacity (around 24,000 referrals which could have qualified for IMCA provision) (DH, 2015). Of these only 1,730 IMCA referrals were actually made (around 7% of the cases) and the conclusion was drawn that the underuse of IMCA support within adult safeguarding is a “cause for concern” (DH 2015, p.26).

The Care Act (2014) makes specific reference to advocacy support, presenting independent advocacy as a statutory requirement “for the purpose of facilitating involvement in the enquiry or review” (Section 68). However, this only comes into force if there is no other “appropriate person” to support the individual, or if the person has “substantial difficulty” in retaining/considering relevant information or communicating their views. As such, it is not clear whether advocacy provision will increase with the implementation of the Care Act (2014).

The (CSSG) (DH, 2014 p. 934) also states that “The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the local authority and other organisations”. The desire for people to receive “seamless advocacy” services is also referred to, as well as the need for people to “not have to repeat their stories to different advocates” representing the Care and/or Mental Capacity Acts (p.94).

Advocates, according to the CSSG (2014, p.102), must have suitable experience, appropriate training, competence, good character, work independently (from the local authority) and engage in regular supervision. Barnes et al. (2002, p.2) write “The service must be **independent** and therefore free from conflicts of interest. This has implications for the way

advocacy is provided and it is proposed that over time, advocacy moves away from provision by agencies which provide other health and social care mental health services". However, advocacy continues to be commissioned by the local authority and therefore there is an argument to be made that it cannot be truly independent.

Over the past few years the profile of advocacy has been raised, but there is scarce evidence to support its effectiveness (Macadam, Watts, & Greig, 2013). Given the new statutory duty to appoint advocates under the Care Act, it is important to consider the evidence around advocacy provision within adult safeguarding.

Advocacy and Adult Safeguarding

A key principle of advocacy is that of 'empowerment', linking it firmly with the first principle of adult safeguarding. Other key principles and values associated with advocacy include 'putting people first' and 'independence' (Action for Advocacy, 2006). Furthermore, the benefits of advocacy include offering practical support, promoting empowerment, promoting social networks, and relationship building (Stewart & MacIntyre, 2013). Gorczyńska and Thompson (2007, p.45) considered the usefulness of advocacy within adult safeguarding, concluding that "IMCAs can be a vital safeguard for adults facing critical life decisions" and that local authorities should "work closely with all advocacy providers to ensure that all people who have potentially abused or been abused have their voice heard".

In a review of IMCA provision in the adult safeguarding process, Redley et al. (2011) adopted a mixed method approach which included data on referrals and semi-structured telephone interviews with managers of IMCA services, IMCAs, adult safeguarding leads, and social workers who had worked with IMCAs. The value of IMCAs within adult safeguarding processes was highlighted within this research by social workers and adult safeguarding leads who described IMCAs as bringing "a different and helpful perspective to the proceedings" (p. 1063).

Irvine et al. (2013) also explored the views of key stakeholders (including representatives from IMCA providers, staff from the safeguarding adults team, and other practitioners involved in adult safeguarding), and reviewed anonymised case notes from five cases within

which IMCAs had been involved. Despite low levels of referrals to IMCAs, overall there was a positive perception of their role (Irvine et al. 2013, p.23).

Alongside the role of IMCAs, there is also a role for other types of advocacy, for example, Independent Mental Health Advocates (IMHAs) (whose provision is a statutory requirement for those detained under the Mental Health Act (2007)) may be involved in adult safeguarding enquiries. Case advocates can also be involved on a short term basis to support the person through the process. General, or case, advocates may also be more readily accessible due to more open referral systems and may work more holistically than IMCAs as a result of the wider scope of their role (Gorczyńska & Thompson, 2007). There is limited research which considers the roles of these types of advocacy within adult safeguarding, despite the benefits that advocacy may bring to those who have capacity, as well as those who lack capacity.

In summary, it is clear that there is a need for greater involvement of older people in adult safeguarding and that advocacy could be beneficial in achieving this. However, there is a need for further research and discussion of advocacy in this context, which is the focus of this paper. The research described in this paper is drawn from a larger PhD project which explored the involvement of older people in adult safeguarding. A key area highlighted by the research was the provision of advocacy within adult safeguarding and it is this element that forms the focus of the current paper.

Method

A critical realist approach allowed for an in depth exploration of advocacy and adult safeguarding by moving away from the subjectification of “the impact of the ‘real’ social world” (Houston 2001, p.858). Within a research paradigm underpinned by critical realism, a retroductive methodology was considered an appropriate approach for this project.

Sampling

Two advocacy services were involved in the research as well as social workers who were employed within two English local authorities. In total, six advocates and eight social workers were interviewed. Two of the advocates interviewed were IMCAs and the others were involved in safeguarding either as IMHAs or as general/case advocates. All of the

advocates had experience of supporting older people within adult safeguarding processes and the social workers interviewed all had experience of carrying out safeguarding investigations with older people. For the purposes of the research 'older people' were identified as those over the age of 65. This was in line with the definition of older people used within the two local authorities under study in the research.

Data collection and analysis

In depth interviews were conducted with all participants and lasted on average 57 minutes. Interviews were semi-structured which allowed the researcher to ensure that the same topics were covered with each interviewee, but also encouraged other topics to be raised and explored.

Thematic analysis was used to analyse the data. The 6 phase guide to conducting thematic analysis, as outlined by Braun & Clarke (2006) was used. This method involves six stages: familiarisation with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes and; interpretation (Braun & Clarke, 2006).

Ethical considerations

Ethics were considered within the same framework as those for social work practice more generally. As such the key principles of 'respect for autonomy', 'beneficence', 'non maleficence' and 'social justice' were encompassed within the research design, process, and within dissemination of research findings (Butler, 2002). Full ethical approval was obtained for the research from XXXX. All participants gave informed consent before they became involved in the research project. To ensure anonymity every participant was assigned a pseudonym and these are used within the current paper.

Limitations of the research

A key limitation of this research is that it did not directly include the voices of older people who had been through safeguarding. They were initially included within the remit of the research, however, a number of challenges were encountered when trying to recruit older

people to be a part of the research and ultimately it was not possible to include their voices within the study (AUTHOR, XXXX).

Findings

A key finding, as reported by participants, was that levels of involvement for older people were low. Advocates were involved in cases where the person had no other representative. A strong theme that was identified was the role that advocates play in keeping the process person centred:

‘And so our role is to try not to be their powerful advocate but to try and present them as, as they really should be presented. It’s who they are as an individual. So when the safeguarding team consider the options they are not just thinking of solving the problem, they are actually considering the individual and that is how I think we can become quite powerful’

(Brian, advocate)

This was related to three core roles that the advocate could carry out within the safeguarding process: supporting the individual; making challenges and independent representation. Additionally, some elements which limited the effectiveness of advocacy were also reported. Overall it was clear from the findings that advocacy would be a useful addition in adult safeguarding in terms of meeting the core principles of the Care Act, especially those of empowerment and proportionality.

Empowerment

Advocacy at its core is in the business of empowerment, aiming to present the person’s needs, wants and wishes over those of professionals. Social worker participants identified that often it was not possible to involve older people directly within the safeguarding process due to issues with capacity or physical mobility and where older people articulated that they did not want to attend meetings. In these cases, they were often represented by family members. Where family members were involved it was identified that there could be potential issues, for example, conflict amongst family members or where family members were representing their own views and wishes, rather than those of the older person.

Independent advocates were identified as a useful way of ensuring that the process stayed focused on the older person's views, rather than on those of their family member. Where older people were not able or did not want to contribute directly advocates could be involved as a way of ensuring the individual's views and wishes were still represented:

*'And some people like you to represent them entirely. And we will do that.
Or you might represent somebody because they can't be there. So that's
important because you are reporting back for them.'*

(Sheila, advocate)

Within this role, advocates identified that they would spend time with the person to get to know what their views and wishes were before presenting these within safeguarding meetings. A key aspect of advocacy in the safeguarding process was the support that they could provide to the older person which included practical support in understanding the process, building confidence so that the person could self-advocate, and assisting with communication.

Whilst social workers involved in the process indicated that a core part of safeguarding was taking the time to explain things to the older person, often the tight time frames associated with adult safeguarding processes and heavy case-loads made this difficult. The benefits of advocacy in overcoming this barrier were related to their ability to spend time with the person before, during, and after meetings to help explain the process. Their experience in being involved in safeguarding meant that they were able to draw on this to enable the individual to better understand the process. Helping the older person by disseminating *"quite a lot of detailed information and [putting] that in a way that is more appropriate for the individual that they support"* was also a clear benefit of advocacy (Hugo, advocate).

This was also related to the use of jargon within meetings. Whilst social workers interviewed indicated that they always tried to avoid the use of jargon it was identified that often professionals *"fall back into jargon and it can become quite complicated for other people to understand what they're talking about"* (Brenda, social worker). Advocates saw an element of their role as being *"to say this is what that means"* (Ken, advocate) and to ensure that

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3 *“questions are put in an understandable and a respectful way to the person ... so that the*
4 *process can move forward”* (Hugo, advocate).
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8 Another key benefit was that advocates were able to assist people to self-advocate, for
9 example, by boosting confidence and *“supporting the service user to express their views”*
10 (Norman, social worker). Advocacy support was identified as useful even when there were
11 family members available to support the individual:
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15 *‘So it would be easier in some ways for them to talk to the professionals*
16 *because they don’t have the same relationship with them as they obviously*
17 *do with their families.’*
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19 (Hugo, advocate)
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24 However, under the current guidance there is no statutory duty to provide such support if
25 there is an “appropriate person” available (i.e. a family member) (except under specific
26 circumstances detailed within the CSSG) (DH 2014, p. 100). This research suggested that
27 where there was a family member available, advocates were not being brought into the
28 process. As such, it seems unlikely that advocacy provision will increase under the Care Act
29 (2014).
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37 *Proportionality*

38 Proportionality is a general principle concerned with the justice of fairness. In terms of
39 advocacy and safeguarding it is the drive towards the harmonious relationship between the
40 concepts of risks and rights. Capacity assessments are often a core part of the safeguarding
41 process in judging an individual’s ability to be involved in the process and related decision
42 making. Involving advocates, especially IMCAs, in the safeguarding process meant that there
43 was a safety net for older people in relation to capacity assessments. For example, if the
44 advocate felt that the capacity assessment had not been carried out correctly then they
45 could *“ask and we can get them to check and see what we think”* (Brian, advocate).
46 Advocates could also challenge within the process if they felt that decisions were made that
47 the individual could make themselves or where delaying a decision might mean that the
48 older person would have the capacity to make it themselves:
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3 *'We might be saying, well can we put things off...and then we can make*
4 *that decision about safeguarding and it might be yes, maybe, or not so*
5 *there's a bit of debate. There are kinds of questions around questions*
6 *sometimes which people can get involved with.'*
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10 (Brian, advocate)

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14 The role of advocacy was also related to ensuring that adult safeguarding measures were
15 *"not too restrictive, that they gave the least restrictive option"* (Sheila, advocate).
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18 19 *Factors which influence the effectiveness of advocacy*

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21 Findings also related to factors which limited the effectiveness of advocacy. Key limitations
22 were resources and relationships.
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25 26 *Relationships*

27 Personal relationships between advocates, service users and social workers were identified
28 as an important factor in the effectiveness of advocacy in adult safeguarding. Relationships
29 were identified as sometimes problematic where advocates felt that other professionals
30 involved in safeguarding did not fully *"embrace"* or understand the role of advocacy in adult
31 safeguarding:
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36 *"it's making sure that everybody knows that you actually do have a role...*
37 *But, there are some people who never have anything to do with advocates,*
38 *and I'm talking about professionals, and sometimes that can be [...] hard*
39 *work"*
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44 (Ken, advocate).
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47 It was identified that developing effective working relationships between professionals
48 could assist with this.
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51 52 *Resources*

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54 Another challenge was related to resources; time and money. For example, as identified
55 above, a key benefit of advocacy was their ability to get to know the individual and present
56 their views and wishes. Advocates indicated that this process took time but that on
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occasions where they were informed about safeguarding that this happened *“last thing”* which made it *“very difficult for effective advocacy to take place”* (Hugo, advocate).

Not being given the resources that they needed was also sometimes an issue, for example, not being given minutes of meetings, or having heavy caseloads which meant that their services were *“stretched”* (Hugo, advocate). This was impacted upon by cutting of national advocacy resources which was identified as an *“issue on a bigger scale”* and which meant that *“it’s difficult to find funding for the training now”* (Brian, advocate).

Such resource issues impact on the rates of referrals to advocacy and advocates within this research identified that there were *“quite a few safeguarding alerts where we are not getting informed or involved”*, even though they were aware of the high volume of cases occurring which they may have assisted with (Barbara, advocate).

Discussion and Conclusion

It has previously been concluded that older people need to regain a position of independence in order to avoid adult safeguarding being driven solely by a professional interpretation of their needs (Harbison & Morrow, 1998). Whilst it is important to recognise the reality of the circumstances of many of those who become involved in adult safeguarding, there is a danger inherent in assuming a lack of ability to be involved and the associated focus with utilising family members as the sole representative of the person within the safeguarding process, rather than drawing on advocacy support. The advantages of advocacy in these cases have been outlined above and it is clear that the provision of advocacy within adult safeguarding can make a contribution towards empowerment and proportionality under the Care Act (2014).

Overall, a key contribution that advocacy makes within adult safeguarding is by ensuring that the voice of the person is recognised and adhered to within decision making. As Cambridge & Parkes (2004, p.724) argued, advocacy input into adult safeguarding can be helpful in shifting *“the balance of power in decision-making towards the service users and away from professional interests”*. Such a shift in power is a requirement in order to avoid

perpetuating the paternalistic elements of adult safeguarding which have long been the subject of criticism (e.g. Humphries 2011).

The key contributions of advocacy, as reported within this paper, have been echoed elsewhere. For example, Sherwood-Johnson (2016), Redley et al (2011) and Irvine et al. (2013) have all highlighted the role that advocacy can play in complimenting adult safeguarding work. However, these authors also drew attention to existing barriers in achieving this. These include low referral rates and issues around understanding the role of advocacy within adult safeguarding. Redley et al. (2011) also found that that teams did not have a comprehensive understanding of the role of an IMCA and described having to “instruct such teams in their duties under the MCA” (p. 1063). Butler & Manthorpe (2016) also identified “limited awareness about the remit of advocacy services” as an issue which emerged within the MSP pilot.

Other research has also highlighted a perceived lack of understanding of the role of IMCAs within adult safeguarding (Irvine et al., 2013), as well as the need for greater provision of advocacy (Irvine et al., 2013; Manthorpe & Martineau, 2010). Within Irvine et al.’s work, this was associated with a perception that the process of involving IMCAs was “complex and created additional work” (2013, p. 4). Despite the issues identified above, the report also acknowledged that many improvements had already been made, for example, training and awareness raising that had taken place and the development of a more accessible IMCA referral form.

Overall it is clear from the presented work that advocacy provision offers a number of key contributions to adult safeguarding, particularly in relation to enabling empowerment for people who are involved in this area and ensuring that the responses to abuse are proportionate. However, the limitations that exist need to be further investigated and considered. There is a need, firstly, to consider the ways in which social workers and other agencies work alongside advocacy services and how these relationships are developed. The participants in this research indicated that developing relationships with individuals promoted their involvement within adult safeguarding cases. Given the multi-agency emphasis within adult safeguarding, development of such relationships should be a key

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3 priority. These can be fostered by the inclusion of advocacy services on SABs (an
4 arrangement which currently exists in many local authorities). Relationship building of this
5 type may also serve to respond to the findings from this research that advocacy provision
6 can be hampered by attitudes and understanding about the role that advocates can play
7 within adult safeguarding. This was also an issue raised within the Scottish context, as
8 reported by Sherwood-Johnson (2016).
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15 Secondly, there is a need to further investigate the way in which advocacy is provisioned.
16 The findings that advocates feel they are often left out of adult safeguarding processes, or
17 that they are contacted at the last minute, has a definitive impact on the contribution that
18 they are able to offer. Issues around the tight time frames for responding to abuse may
19 contribute to this occurring and there is a clear need for greater flexibility within the process
20 (AUTHOR, XXXX). Again, this was found in Sherwood-Johnson’s work; “the findings with
21 respect to late referrals raise the question as to whether an appropriate balance is being
22 struck between procedures to ensure timeliness, on the one hand, and flexibility to foster
23 person-centred practice including the involvement of advocacy, on the other” (2016, p. 117).
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33 Sherwood-Johnson (2016) also highlighted that the experience in England, where there is an
34 attempt to align personalisation and adult safeguarding, could help to inform this debate in
35 Scotland. The findings from this research, however, suggest that this is an issue that is also
36 being experienced within England and that it warrants further attention and consideration.
37 It may be that with the recently shifting practice guidelines under the Care Act (which
38 suggest that a greater degree of flexibility may be possible in relation to safeguarding
39 enquiries) these issues may become less common. However, at this stage it is difficult to
40 foresee what concrete changes will occur in relation to late referrals.
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49 Whilst there are some barriers to advocacy involvement in adult safeguarding, it is clear that
50 they play an important role within this multi-agency area of working. In particular, their role
51 in creating a more empowering and proportionate approach to adult safeguarding highlights
52 the importance of their continuing involvement in this area. We need to be mindful of how
53 we develop and commission advocacy services. Improving uptake of advocacy within adult
54 safeguarding should be a key priority and addressing some of the concerns raised within this
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paper and others offers a starting point for developing this area. Demonstrating clear effectiveness is vital for advocacy to cement its legitimacy and secure long term funding.

In conclusion, whilst the Care Act principle of empowerment may be referring to individual empowerment, political empowerment is also necessary for people to be genuinely involved in “making change” (Beresford, 2016, p. 343). The increasing move towards the co-production of services and recognition of participatory approaches within social policy may offer a route forward in developing a more inclusive way of working. Advocacy can make a strong contribution to empowerment and proportionality within adult safeguarding counteracting some of the shortcomings in provision indicated in this paper. Discussions should continue around how we provide this within a climate of shrinking resources.

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Renegotiating Power in Adult Safeguarding: The Role of Advocacy

Abstract

Purpose:

The increased involvement of adults at risk in the safeguarding process has become a prominent issue within English safeguarding policy. However, there is evidence to suggest that actual levels of involvement are still low. This paper presents findings from a PhD study in relation to the benefits of advocacy in supporting this involvement in adult safeguarding for older people.

Methodology:

Participants in the study included advocates and social workers who had experience of working with older people through the safeguarding process within two North East England local authorities. A critical realist approach through in-depth interviews was taken with all the participants.

Findings:

The research findings in relation to the benefits of advocacy in supporting older people going through safeguarding processes are reported. The practical limitations and factors which help and hinder advocacy support within the process are also considered. **The theoretical implications for power, empowerment and advocacy will also be explored here.**

Research limitations:

A key limitation of this research is that it did not **directly** include older people who had been through safeguarding amongst the participants.

Implications:

Key implications for practice and policy are discussed.

Originality:

The paper provides an overview and critique of empowerment in adult safeguarding and the role that advocates can play in promoting this key principle.

Value:

A key area highlighted by the research was the benefits of advocacy provision within adult safeguarding.

Keywords: advocacy, advocates, adult safeguarding, empowerment, power, older people, social work

Introduction

The involvement of adults at risk within safeguarding procedures has increasingly become a focus within English safeguarding policy since the publication of No Secrets (DH, 2000). This involvement is associated with the personalisation agenda which promotes the importance of offering service users choice and control (Carr, 2012). However, the ‘top-down’ approach of this agenda has been criticised by some for its assumption that such autonomy is equally accessible to all. Ellis & Preston-Shoot (2012, p. 168), for example, draw attention to the “controlling” of information as a “means of enacting stereotyped judgements about capacity in order to manage people’s access to direct payment”. Furthermore, those who may be structurally or systemically excluded from accessing their rights as citizens within a political climate of neoliberalism may struggle to access their rights to direct their own care and support needs (Lloyd, 2010; Stewart, 2011). Within an older population this applies particularly to those who may lack capacity to make some decisions around their care, although it may equally apply to those who do not have the confidence or the knowledge to be able to do so (AUTHOR, XXXX). These people in particular may benefit from advocacy support in bridging health and social care services. Advocacy at its core is about engaging with people and helping them to increase “their sense of power [...] to feel more confident, to become more assertive and gain increased choices” (AUTHOR, XXXX). However, within the remit of adult safeguarding, there is some evidence to suggest that advocacy involvement is limited (Irvine et al., 2013; Manthorpe & Martineau, 2010).

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Advocacy itself is contested in terms of its definition, practice, and potential for positive outcomes. Forbat & Atkinson (2005), for example, highlight the lack of consensus around both its meaning and effectiveness. Advocacy has a tendency to be misunderstood as purely a complaints procedure or as a distinct role that professionals such as social workers can pick up in addition to their existing work (AUTHOR, XXXX). This potential for misunderstanding the role of advocacy has been noted by Redley et al., (2011) in relation to adult safeguarding.

There is limited research exploring the involvement of adults at risk within adult safeguarding, but where research has considered this area there is consensus that levels of involvement are low (Corkhill & Walker, 2010; Jeary, 2004; Wallcraft & Sweeney, 2011; Wallcraft, 2012). Wallcraft and Sweeney (2011, p.19) identified a number of barriers to involvement in adult safeguarding processes. These included difficulties in conceptualising risk, exclusion of some groups due to being seen as “lacking value”, and unhelpful procedures for investigating abuse. They also identified that advocacy could assist in enabling adults at risk to be involved in the process of safeguarding (Wallcraft and Sweeney, 2011; Wallcraft, 2012).

This paper presents findings from a PhD study (undertaken at xxxx) which explored the involvement of older people within adult safeguarding. Older people were the focus of this research because they are highly represented within adult abuse and neglect prevalence figures (NHS Information Centre, 2014) and to reduce the remit of the research in order to allow for a more in depth exploration. This paper is specifically concerned with the ways in which advocates help facilitate the involvement of older people within adult safeguarding, as well highlighting factors which either support or inhibit their work.

Policy Framework and Advocacy Provision

The Care Act (2014) replaced previous adult safeguarding policy and placed this area of work on a statutory footing. ~~A key emphasis throughout the development of safeguarding policy has been that of multi-agency working, reflected in the statutory duty for every local authority to establish a Safeguarding Adults Board (SAB) (a multi-agency committee which oversees~~

~~adult safeguarding in the local area).~~ The Care and Support Statutory Guidance (CSSG) (DH, 2014) which accompanied the legislation defines adult safeguarding as:

Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action

(DH 2014, p.1)

Adult safeguarding is primarily located within the interpersonal dynamics between the abuser and the perpetrator. As such it fails to acknowledge wider societal and structural factors which have been identified by older people as being abusive (O'Brien et al., 2011; WHO/INPEA, 2002). Within the research conducted by O'Brien et al. (2011) and WHO/INPEA (2002) the erosion of personhood was also identified by older people as being abusive. This suggests that failing to involve older people within adult safeguarding processes can be perceived by them as abusive in itself. Sherwood-Johnson et al. (2013, p.117) also concluded that adult safeguarding "itself might undermine an adult's strengths, skills and sense of self, depending on the way it is performed". This underscores the need for effective processes which are person centred and allow the individual to make choices and have control over decision making. This is needed both within individual safeguarding procedures, as well as at a more strategic level so that older people's voices are reflected within policy development in this area.

Adults at risk are described within adult safeguarding policy as those who are "unable to protect [themselves] against [...] abuse or neglect or the risk of it" as a result of their "needs for care and support" (Care Act 2014, Section 42). However, this construction of vulnerable adults identifies this group on the basis of individual, inherent characteristics, rather than considering wider contextual and structural factors. Vulnerability here becomes a permanent aspect of identity rather than a temporary situational effect. The final aspect of the definition, that the individual is "unable" to protect themselves, also places emphasis for protecting and preventing abuse on the local authority, potentially removing the

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individual’s agency within responses to adult safeguarding concerns. This raises questions about how the independence of the individual is respected within adult safeguarding processes.

The Care Act (2014) also incorporates six key principles:

1. Empowerment – Personalisation and the presumption of person-led decisions and informed consent.
2. Prevention – It is better to take action before harm occurs.
3. Proportionality – Proportionate and least intrusive response appropriate to the risk presented.
4. Protection – Support and representation for those in greatest need.
5. Partnership – Local solutions through services working with their communities. Communities having a part to play in preventing, detecting and reporting neglect and abuse.
6. Accountability – Accountability and transparency in delivering safeguarding.

(DH 2014)

Safeguarding is, in reflection of these principles, comparable to advocacy as it shifts its practice from a process led approach to a more person centered approach, which focuses on the adult at risk’s desired outcomes. This approach was strongly influenced by the ‘Making Safeguarding Personal’ (MSP) work which has been incorporated into the CSSG (DH, 2014). The MSP guidance states the need to review how advocacy is provisioned within adult safeguarding, as well as highlighting the usefulness of advocacy in “situations where people have capacity as well as where they lack capacity” (Lawson et al. 2014, p.11). Other key principles and values associated with advocacy include ‘putting people first’ and ‘independence’ (Action for Advocacy, 2006). Furthermore, the benefits of advocacy include offering practical support, promoting empowerment, promoting social networks, and relationship building (Stewart & MacIntyre, 2013).

Advocacy support can be provisioned under the Mental Capacity Act (2005). This statute gives a power to local authorities to appoint an Independent Mental Capacity Advocate (IMCA) in cases where the person lacks capacity to make key decisions (regardless of whether there is

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3 a family member or friend supporting them). However, research which has examined IMCA
4 provision within adult safeguarding processes has found that it is often limited (Irvine et al.,
5 2013). In 2013/2014 there were a reported 88,260 safeguarding referrals concluded, of which
6 28% lacked capacity (around 24,000 referrals which could have qualified for IMCA provision)
7 (DH, 2015). Of these only 1,730 IMCA referrals were actually made (around 7% of the cases)
8 and the conclusion was drawn that the underuse of IMCA support within adult safeguarding
9 is a “cause for concern” (DH 2015, p.26).
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18 Alongside the role of IMCAs, there is also a role for other types of advocacy, for example,
19 Independent Mental Health Advocates (IMHAs) [whose provision is a statutory requirement
20 for those detained under the Mental Health Act (2007)] may be involved in adult safeguarding
21 enquiries. Case advocates can also be involved on a short term basis to support the person
22 through the process. General, or case, advocates may also be more readily accessible due to
23 more open referral systems and may work more holistically than IMCAs as a result of the
24 wider scope of their role (Gorczyńska & Thompson, 2007). There is limited research which
25 considers the roles of these types of advocacy within adult safeguarding, despite the benefits
26 that advocacy may bring to those who have capacity, as well as those who lack capacity.
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37 The Care Act (2014) also makes specific reference to advocacy support, presenting
38 independent advocacy as a statutory requirement “for the purpose of facilitating involvement
39 in the enquiry or review” (Section 68). Advocacy provision under the Care Act (2014) only
40 comes into force if there is no other “appropriate person” to support the individual, or if the
41 person has “substantial difficulty” in retaining/considering relevant information or
42 communicating their views. As such, it is not clear whether advocacy provision will increase
43 with the implementation of the Care Act (2014). The (CSSG) (DH, 2014 p. 934) also states that
44 “The role of the independent advocate is to support and represent the person and to facilitate
45 their involvement in the key processes and interactions with the local authority and other
46 organisations”. The desire for people to receive “seamless advocacy” services is also referred
47 to, as well as the need for people to “not have to repeat their stories to different advocates”
48 representing the Care and/or Mental Capacity Acts (p.94).
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Advocates, according to the CSSG (2014, p.102), must have suitable experience, appropriate training, competence, good character, work independently (from the local authority) and engage in regular supervision. Barnes et al. (2002, p.2) write “The service must be **independent** and therefore free from conflicts of interest. This has implications for the way advocacy is provided and it is proposed that over time, advocacy moves away from provision by agencies which provide other health and social care mental health services”. However, advocacy continues to be commissioned by the local authority and therefore there is an argument to be made that it cannot be truly independent.

The Care Act (2014) highlights the importance of empowerment and placing the individual at the centre of adult safeguarding processes and associated decision making. There is an established need for this focus with evidence (gathered prior to the implementation of the Care Act) suggesting that older people are often not involved within adult safeguarding processes (Wallcraft & Sweeney, 2011). **Empowerment is, however, challenging to put into practice; philosophically it's not something a social worker can 'do' to someone. Additionally, many have cited the difficulty of promoting empowerment alongside duties to manage risk and meet organisational needs (AUTHOR, XXXX, Wallcraft and Sweeney, 2011). The concept of empowerment itself is problematic. Whilst it is typically seen as being associated with sharing or handing over power, this in turn is difficult to align with modern social work practice. For example, it has been reported that social workers feel a sense of “powerlessness” within an increasingly privatised welfare system which promotes the “deprofessionalisation of social work” (Ferguson, 2007, p. 401). Such privatisation positions involvement as consumer choice and control, rather than aligning with the more democratic (and less individualistic) conception which has been propounded by service user groups. Advocacy at its core is in the business of empowerment, aiming to present the person's needs, wants and wishes over those of professionals. As such, there is a need to explore further the benefits of advocacy in meeting the key principles of the Care Act.**

Over the past few years the profile of advocacy has been raised, but there is scarce evidence to support its effectiveness (Macadam, Watts, & Greig, 2013). Given the new statutory duty to appoint advocates under the Care Act, it is important to consider the evidence around advocacy provision within adult safeguarding. ~~The research described in this paper is drawn~~

from a larger PhD project which explored the involvement of older people in adult safeguarding. A key area highlighted by the research was the provision of advocacy within adult safeguarding and it is this element that forms the focus of the current paper.

Method

A critical realist approach allowed for an in depth exploration of advocacy and adult safeguarding by moving away from the subjectification of “the impact of the ‘real’ social world” (Houston 2001, p.858). Critical realism has an emancipatory approach as it seeks to expose and explore social injustice (Bhaskar, 1979, 1989). As such it was felt to be a suitable framework for this research. Ontologically, critical realism holds that there is an objective reality which is stratified, existing on three levels. These are the ‘real’ (generative mechanisms or structures which are not observable, but which are responsible for what we observe), the ‘actual’ (events to which these mechanisms give rise), and the ‘empirical’ (events which are actually observed). These mechanisms are not considered to operate in a simple cause and effect relationship, but rather they are contextually contingent and research underpinned by critical realism seeks to uncover and understand these mechanisms.

Epistemologically, critical realism positions itself as interpretive; our understanding of reality is ‘concept dependent’ (Bhaskar, 1979, 1985). However, Bhaskar argues that although social products are concept dependent, they always have a “material dimension” (Bhaskar, 1989, p. 4). Critical realism would therefore acknowledge the reality of abuse, but still understand that our responses to it are social constructed. Nevertheless, these constructions have a real impact; the way in which we create and construct adult safeguarding is not arbitrary; “these structures may be socially constructed but they are nevertheless real and have power causal effects” (Elder-Vass, 2012, p. 74).

Research underpinned by critical realism therefore seeks to uncover and understand these mechanisms. Within this acknowledgement of the complex interplay between different causal powers (mechanisms) the focus is not on the search for certainties, but to “construct explanations” which may then be tested (Bhaskar, 1989, p. 69). As such, a retroductive

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methodology was considered to be an appropriate approach for this study. Retroduction involves moving away from the observation of events to a “conceptualisation of transfactual conditions” (Danermark et al., 1997, p. 96). Retroduction is about searching for a causal explanation for the phenomenon, although such explanations are always contextually contingent (Danermark et al., 1997).

Sampling

Two advocacy services were involved in the research as well as social workers who were employed within two English local authorities. In total, six advocates and eight social workers were interviewed. Two of the advocates interviewed were IMCAs and the others were involved in safeguarding either as IMHAs or as general/case advocates. All of the advocates had experience of supporting older people within adult safeguarding processes and the social workers interviewed all had experience of carrying out safeguarding investigations with older people. For the purposes of the research ‘older people’ were identified as those over the age of 65. This was in line with the definition of older people used within the two local authorities under study in the research.

Data collection and analysis

Blom and Moren (2011) describe mechanisms as “analytical constructs” which are causes, motives and choices influencing observable events (Blom and Moren, 2011, p. 60). Bhaskar (1986) has also argued that reasons are causal and therefore the starting point for understanding human behaviour is the explanations that people themselves give. As such a core element of the research was key stakeholders’ accounts; interviews were used as the primary source of data collection. In depth interviews were conducted with all participants and lasted on average 57 minutes. Interviews were semi-structured which allowed the researcher to ensure that the same topics were covered with each interviewee, but also encouraged other topics to be raised and explored.

Thematic analysis was used to analyse the data. The 6 phase guide to conducting thematic analysis, as outlined by Braun & Clarke (2006) was used. This method involves six stages: familiarisation with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes and; interpretation (Braun & Clarke, 2006). The process of

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3 interpretation requires a move from descriptive accounts of the patterns found within the
4 data to a consideration of what accounts for them. Braun and Clarke (2006) suggest that
5 this involves going “beyond the ‘surface’ of the data” and asking questions such as “what is
6 the overall story the different themes reveal about the topic?” (Braun and Clarke, 2006, p.
7 94). This fits with the overall aim of retrodution which questions why observed events
8 occur in the manner that they do (Danermark et al., 1997).

16 *Ethical considerations*

17 **Ethics were considered within the same framework as those for general social work practice.**

18 As such the key principles of ‘respect for autonomy’, ‘beneficence’, ‘non maleficence’ and
19 ‘social justice’ were encompassed within the research design, process, and within
20 dissemination of research findings (Butler, 2002). Full ethical approval was obtained for the
21 research from XXXX. All participants gave informed consent before they became involved in
22 the research project. To ensure anonymity every participant was assigned a pseudonym and
23 these are used within the current paper.

32 *Limitations of the research*

33 A key limitation of this research is that it did not directly include the voices of older people
34 who had been through safeguarding. They were initially included within the remit of the
35 research, however, a number of challenges were encountered when trying to recruit older
36 people to be a part of the research and ultimately it was not possible to include their voices
37 within the study (AUTHOR, XXXX).

46 **Findings**

47 **This section presents a brief overview of the wider PhD study findings, before exploring in**
48 **further detail the key findings related to advocacy provision within adult safeguarding. Two**
49 **wider key themes were related to older people’s involvement within adult safeguarding.**
50 **These were “older people as unable to be involved” and “older people as unwilling to be**
51 **involved” (as represented within the figure below in Figure 2). The first of these themes**
52 **reflected participants’ accounts of how older people are often unable to be involved in adult**
53 **safeguarding as a result of both individual characteristics (such as capacity issues) and**
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because of the inaccessibility of the process (for example, issues with the accessibility of meetings and key information about the safeguarding process). The second wider key theme, “older people as unwilling to be involved” reflected participants’ accounts of how older people, who had capacity, could choose not to be involved in adult safeguarding. This choice could be limited by other factors, such as potentially finding the process intimidating, concerns about potential outcomes of adult safeguarding, and whether or not they agreed with professionals about the level of risk that they faced. It was also highlighted that this choice may be limited by professionals themselves. For example, in some cases concerns about risk management, or the individual worker’s willingness to involve the older person were reported as reducing the older person’s ability to make an informed choice about their involvement. Another key finding, as reported by participants, was that levels of involvement for older people were low. These two wider key themes were identified as the core reasons why this might be the case. In light of these findings, the data gathered for the PhD study was reviewed and key factors related to advocacy support were examined in further detail. These findings are the focus of the rest of this paper and are presented below.

Advocacy support.

Advocates were involved in cases where the person had no other representative. A strong theme that was identified was the role that advocates play in keeping the process person centred:

‘And so our role is to try not to be their powerful advocate but to try and present them as, as they really should be presented. It’s who they are as an individual. So when the safeguarding team consider the options they are not just thinking of solving the problem, they are actually considering the individual and that is how I think we can become quite powerful’
(Brian, advocate)

Overall there were three key themes related to advocacy provision: supporting the individual; making challenges and independent representation. Additionally, some elements which limited the effectiveness of advocacy were also reported. These findings are presented below.

Independent Representation.

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3 Social worker participants identified that often it was not possible to involve older people
4 directly within the safeguarding process due to issues with capacity or physical mobility and
5 where older people articulated that they did not want to attend meetings. In these cases,
6 they were often represented by family members. Where family members were involved it
7 was identified that there could be potential issues, for example, conflict amongst family
8 members or where family members were representing their own views and wishes, rather
9 than those of the older person. Independent advocates were identified as a useful way of
10 ensuring that the process stayed focused on the older person's views, rather than on those
11 of their family member. Where older people were not able or did not want to contribute
12 directly advocates could be involved as a way of ensuring the individual's views and wishes
13 were still represented:
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24 *'And some people like you to represent them entirely. And we will do that.*

25 *Or you might represent somebody because they can't be there. So that's*
26 *important because you are reporting back for them.'*

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30 (Sheila, advocate)
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34 **Within this role, the independence of the advocate, as someone who was there to "help**
35 **people get their views heard", "to help them get the information for them to make their**
36 **decisions" and to "go along as a representative" was highlighted. In one advocate's words**
37 **"...my own personal views are totally irrelevant. It's the views of the person" (Ken,**
38 **advocate).**
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45 ***Supporting the person***

46 Advocates identified that they would spend time with the person to get to know what their
47 views and wishes were before presenting these within safeguarding meetings. A key aspect
48 of advocacy in the safeguarding process was the support that they could provide to the older
49 person which included practical support in understanding the process, building confidence so
50 that the person could self-advocate, and assisting with communication.
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58 Whilst social workers involved in the process indicated that a core part of safeguarding was
59 taking the time to explain things to the older person, often the tight time frames associated
60 with adult safeguarding processes and heavy case-loads made this difficult. The benefits of

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advocacy in overcoming this barrier were related to their ability to spend time with the person before, during, and after meetings to help explain the process. Their experience in being involved in safeguarding meant that they were able to draw on this to enable the individual to better understand the process. Helping the older person by disseminating *“quite a lot of detailed information and [putting] that in a way that is more appropriate for the individual that they support”* was also a clear benefit of advocacy (Hugo, advocate).

This was also related to the use of jargon within meetings. Whilst social workers interviewed indicated that they always tried to avoid the use of jargon it was identified that often professionals *“fall back into jargon and it can become quite complicated for other people to understand what they’re talking about”* (Brenda, social worker). Advocates saw an element of their role as being *“to say this is what that means”* (Ken, advocate) and to ensure that *“questions are put in an understandable and a respectful way to the person ... so that the process can move forward”* (Hugo, advocate).

Another key benefit was that advocates were able to assist people to self-advocate, for example, by boosting confidence and *“supporting the service user to express their views”* (Norman, social worker). Advocacy support was identified as useful even when there were family members available to support the individual:

‘So it would be easier in some ways for them to talk to the professionals because they don’t have the same relationship with them as they obviously do with their families.’
(Hugo, advocate)

Making challenges

Capacity assessments are often a core part of the safeguarding process in judging an individual’s ability to be involved in the process and related decision making. Involving advocates, especially IMCAs, in the safeguarding process meant that there was a safety net for older people in relation to capacity assessments. For example, if the advocate felt that the capacity assessment had not been carried out correctly then they could *“ask and we can get them to check and see what we think”* (Brian, advocate). Advocates could also challenge within the process if they felt that decisions were made that the individual could make

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3 themselves or where delaying a decision might mean that the older person would have the
4 capacity to make it themselves:
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7 *'We might be saying, well can we put things off...and then we can make that*
8 *decision about safeguarding and it might be yes, maybe, or not so there's a*
9 *bit of debate. There are kinds of questions around questions sometimes*
10 *which people can get involved with.'*
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14 (Brian, advocate)
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18 The role of advocacy was also related to ensuring that adult safeguarding measures were "*not*
19 *too restrictive, that they gave the least restrictive option*" (Sheila, advocate).
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22 23 24 *Factors which influence the effectiveness of advocacy*

25 Findings also related to factors which limited the effectiveness of advocacy. Key limitations
26 were resources and relationships.
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29 30 31 *Relationships*

32 Personal relationships between advocates, service users and social workers were identified
33 as an important factor in the effectiveness of advocacy in adult safeguarding. Relationships
34 were identified as sometimes problematic where advocates felt that other professionals
35 involved in safeguarding did not fully "*embrace*" or understand the role of advocacy in adult
36 safeguarding:
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39 *"it's making sure that everybody knows that you actually do have a role...*
40 *But, there are some people who never have anything to do with advocates,*
41 *and I'm talking about professionals, and sometimes that can be [...] hard*
42 *work"*
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46 (Ken, advocate).
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53 It was identified that developing effective working relationships between professionals could
54 assist with this.
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Another challenge was related to resources; time and money. For example, as identified above, a key benefit of advocacy was their ability to get to know the individual and present their views and wishes. Advocates indicated that this process took time but that on occasions where they were informed about safeguarding that this happened “*last thing*” which made it “*very difficult for effective advocacy to take place*” (Hugo, advocate).

Not being given the resources that they needed was also sometimes an issue, for example, not being given minutes of meetings, or having heavy caseloads which meant that their services were “*stretched*” (Hugo, advocate). This was impacted upon by cutting of national advocacy resources which was identified as an “*issue on a bigger scale*” and which meant that “*it’s difficult to find funding for the training now*” (Brian, advocate).

Such resource issues impact on the rates of referrals to advocacy and advocates within this research identified that there were “*quite a few safeguarding alerts where we are not getting informed or involved*”, even though they were aware of the high volume of cases occurring which they may have assisted with (Barbara, advocate).

The key contributions of advocacy, as reported within this paper, have been echoed elsewhere. For example, Sherwood-Johnson (2016), Redley et al (2011) and Irvine et al. (2013) have all highlighted the role that advocacy can play in complimenting adult safeguarding work. However, these authors also drew attention to existing barriers in achieving this. These include low referral rates and issues around understanding the role of advocacy within adult safeguarding. Redley et al. (2011) also found that that teams did not have a comprehensive understanding of the role of an IMCA and described having to “instruct such teams in their duties under the MCA” (p. 1063). Butler & Manthorpe (2016) also identified “limited awareness about the remit of advocacy services” as an issue which emerged within the MSP pilot.

Other research has also highlighted a perceived lack of understanding of the role of IMCAs within adult safeguarding (Irvine et al., 2013), as well as the need for greater provision of advocacy (Irvine et al., 2013; Manthorpe & Martineau, 2010). Within Irvine et al.’s work, this was associated with a perception that the process of involving IMCAs was “complex and

created additional work” (2013, p. 4). Despite the issues identified above, the report also acknowledged that many improvements had already been made, for example, training and awareness raising that had taken place and the development of a more accessible IMCA referral form.

Discussion

It has previously been concluded that older people need to regain a position of independence in order to avoid adult safeguarding being driven solely by a professional interpretation of their needs (Harbison & Morrow, 1998). Whilst it is important to recognise the reality of the circumstances of many of those who become involved in adult safeguarding, there is a danger inherent in assuming a lack of ability to be involved and the associated focus with utilising family members as the sole representative of the person within the safeguarding process, rather than drawing on advocacy support. The advantages of advocacy in these cases have been outlined above and it is clear that the provision of advocacy within adult safeguarding can make a contribution towards empowerment and proportionality under the Care Act (2014).

However, for advocacy to be effective there is a need to consider some of the limitations that this paper has highlighted. These include the way in which advocacy is commissioned and provisioned, the interpersonal relationships between advocates and other professionals, and the way in which empowerment is framed within policy and practice. These are discussed below.

The Provision of Advocacy

There is a need, firstly, to further investigate the way in which advocacy is provisioned. The findings that advocates feel they are often left out of adult safeguarding processes, or that they are contacted at the last minute, has a definitive impact on the contribution that they are able to offer. Issues around the tight time frames for responding to abuse may contribute to this occurring and there is a clear need for greater flexibility within the process (AUTHOR,

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XXXX). Again, this was found in Sherwood-Johnson’s work; “the findings with respect to late referrals raise the question as to whether an appropriate balance is being struck between procedures to ensure timeliness, on the one hand, and flexibility to foster person-centred practice including the involvement of advocacy, on the other” (2016, p. 117).

Sherwood-Johnson (2016) also highlighted that the experience in England, where there is an attempt to align personalisation and adult safeguarding, could help to inform this debate in Scotland. The findings from this research, however, suggest that this is an issue that is also being experienced within England and that it warrants further attention and consideration. It may be that with the recently shifting practice guidelines under the Care Act (which suggest that a greater degree of flexibility may be possible in relation to safeguarding enquiries) these issues may become less common. However, at this stage it is difficult to foresee what concrete changes will occur in relation to late referrals.

The Commissioning of Advocacy

Secondly, issues with the availability of advocacy have been raised. The way in which advocacy is commissioned is therefore an important area to consider. The Care Act highlights the need to ensure choice and focus on wellbeing when commissioning services. Additionally, SCIE guidance (SCIE 2015, p.21) highlights the importance of using “evidence about what works” when commissioning services, further emphasising the need for research which explores the role of advocacy within adult safeguarding and provides evidence for the benefits of advocacy provision within adult safeguarding. However, issues with the commissioning of advocacy services have been cited. For example, True Voice, an organisation which aims to “make rights a reality”, carried out a scoping exercise around Care Act advocacy provision with the results published in 2015. Of 34 organisations who responded, none believed that there was a “clear and realistic link” between the proposed funding and projected uptake for advocacy services. Furthermore, only one in nine respondents believed that funding would be sufficient to ensure adequate access to advocacy provision under the Care Act (True Voice, 2015).

Issues with funding may lie at the heart of advocacy provision, with local authorities forced to make difficult decisions around allocation of funds. Projected costs for advocacy provision in 2015/16 were estimated at £16m, although it was considered that this could rise to £24.5m by 2024/25, due to potential increases in previously unreported cases (DH, 2014). Evidence has suggested the potential for advocacy to offset these costs; “early findings indicate that for every £1 invested in older people’s advocacy, a social return investment of £8.00 is returned” (DH, 2014, p. 76). This suggests that in addition to the benefits of advocacy highlighted by this article and others, there is a “monetary value” attached to “increased advocacy service” (DH, 2014, p. 76).

Relationships

Thirdly, there is a need to consider the ways in which social workers and other agencies work alongside advocacy services and how these relationships are developed. The participants in this research indicated that developing relationships with individuals promoted their involvement within adult safeguarding cases. Given the multi-agency emphasis within adult safeguarding, development of such relationships should be a key priority. These can be fostered by the inclusion of advocacy services on SABs (an arrangement which currently exists in many local authorities). Relationship building of this type may also serve to respond to the findings from this research that advocacy provision can be hampered by attitudes and understanding about the role that advocates can play within adult safeguarding. This was also an issue raised within the Scottish context, as reported by Sherwood-Johnson (2016). **SCIE guidance on the implications of personalisation for advocates (ref) states that advocacy means “working alongside people who use services to ensure that there is a genuine shift in control and decision making in their favour” (ref). However, as previously mentioned, this focus on shifting power from professionals to service users can be problematic. A more nuanced understanding of power and advocacy, discussed below, may help to shift the balance still further, for example, by expanding the remit of involvement and enabling older people to have greater choice and control over the way in which adult safeguarding policy is developed and implemented.**

Power and Empowerment

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Finally, there is a need to consider and debate the concept of ‘empowerment’, and how it is understood and applied in practice and policy. The findings from this study and others suggest that older people are often not engaged within adult safeguarding processes. Whilst attempts are made to “hear the voice” of the person, arguably this not a truly empowering experience for them (AUTHOR, XXXX). This paper has highlighted the role that advocates can play in adult safeguarding including supporting the person, providing independent representation, and making challenges within the process. Overall, these findings suggest that advocates can and do assist in meeting the key principle of the Care Act (2014) in relation to ‘empowerment’ by ensuring that the voice of the person is recognised and adhered to within decision making.

As Cambridge & Parkes (2004, p.724) argued, advocacy input into adult safeguarding can be helpful in shifting “the balance of power in decision-making towards the service users and away from professional interests”. Such a shift in power is a requirement in order to avoid perpetuating the paternalistic elements of adult safeguarding which have long been the subject of criticism (e.g. Humphries 2011). **Advocacy at its core is in the business of empowerment, aiming to present the person’s needs, wants and wishes over those of professionals. However, as previously discussed, empowerment is not easy to achieve. The way in which advocates assist within the safeguarding process can be viewed as empowerment at an individual, or micro level. Power, in this depiction, is seen as a commodity; something which can be taken or shared. This form of power has been conceptualised as “visible power” by Lukes (1974), whereby there are winners and losers in the struggle for power. In this case, it can be linked to the advocates role in making challenges within the process and ensuring that older people do not ‘lose’ within the safeguarding process, for example, by making sure that their views and wishes are respected and adhered to. On the surface then, the advocates role in ‘empowerment’ can be viewed as an exercise in control over decision making which is reflected in the definition of advocacy given by SCIE that advocacy means “working alongside people who use services to ensure that there is a genuine shift of control and decision making in their favour” (SCIE, 2009)**

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4 A second dimension of power, suggested by Lukes, is that power can also operate to control
5 who gets a seat at the decision making table. This in turn can be seen within the guidance
6 for adult safeguarding. Firstly, in relation to the increased focus of involvement for adults
7 at risk and for advocates; these spaces are now more open for both advocates and for older
8 people. As such, in this sense adult safeguarding can be viewed as more 'empowering' for
9 both older people and for advocates. Advocates in turn may have a greater scope to fulfil
10 an empowering role within the process under this new guidance (as demonstrated by the
11 findings from this paper and others). In reflection of these two dimensions of power it could
12 be argued that advocates can and do ensure that the principle of empowerment is upheld
13 within adult safeguarding processes. However, this depends on an understanding of power
14 that is located within interpersonal dynamics. This ignores the diverse ways in which power
15 operates and the potential for empowerment to occur at a societal or political level.
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29 A third dimension of power, proposed by Lukes, was that power operates to shape people's
30 attitudes and perceptions in order that they come to accept social practices. This form of
31 power is 'invisible'; it shapes our practices through our internalisation of norms and cultural
32 practices. This 'invisible' power is reflected in areas such as the attempt to align an
33 increased focus on involvement and empowerment with the public desire to be more
34 actively involved in dictating their health and social care needs. In the case of the Care Act,
35 a focus on empowerment and a supposed increased utilisation of advocacy has aligned with
36 the public desire to move away from an adult safeguarding system which the review of No
37 Secrets suggested can protect at the expense of independence (DH, 2009). In the Care Act,
38 for example, advocacy is only considered in relation to individual support, for when an
39 individual has no appropriate person to support them and substantial difficulty in
40 understanding the process. The purpose of advocacy here is to facilitate the involvement of
41 the individual. As such, this "invisible power" shapes acceptance of what advocacy is, or can
42 be, and when it might be useful.
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56 It seems overall, therefore, that in relation to "visible" and "hidden" power, some elements
57 may be transferred to older people (either directly or with the support of advocates). The
58 third dimension, however, continues to reside with policy developers and implementers.
59 Through this framework of power and empowerment, it can be seen that whilst the Care
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Act (2014) may prioritise empowerment, the delivery and form of this is restricted. This is not to negate the positive elements of having empowerment embedded within the legal framework for safeguarding. Individuals who access power in this way may indeed feel more in control of the safeguarding process, supported by advocacy and achieve outcomes that are more satisfactory to them. Empowerment in this form therefore has many benefits. The updated policy framework for adult safeguarding and the increased focus on outcomes and “Making Safeguarding Personal” have indeed been shown to have positive benefits for adults at risk, for example, helping the person “think about what they wanted” and enabling social workers to practice in a more “person centred” manner (Manthorpe et al., 2014, p. 100).

Lukes’ work on power, in relation to advocacy and adult safeguarding, raises the notion that for empowerment to be meaningful, consideration of these three forms of power needs to be undertaken. This involves transfer of control and resources (visible power), access to decision making spaces (hidden power), and a greater consciousness and understanding of oppression and the forms that this can take in order to facilitate a desire to challenge the shaping of norms and practices that exclude older people (invisible power). These include, for example, the ways in which adults at risk are positioned within policy, ageist attitudes and the acknowledgement and challenging of wider societal and structural factors which older people perceive as abusive (O’Brien et al., 2011; WHO/INPEA, 2002). As previously discussed, not all people may want or have the ability to do this. Advocacy therefore should consider a role in representing and empowering people at this structural level, as well as at an individual level. This wider understanding of the role of advocacy and empowerment may be a key stepping stone towards participatory approaches to social policy, a “major attempt to enable people to speak for themselves, instead of being spoken for” (Beresford, 2016, p. 173). This would shift the focus of advocacy from being solely about the individual, to being more of a collective lobby against neoliberalism and the associated consumerist approach to involvement and empowerment.

Conclusion

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3 Whilst there are some barriers to advocacy involvement in adult safeguarding, it is clear that
4 they play an important role within this multi-agency area of working. In particular, their role
5 in creating a more empowering and proportionate approach to adult safeguarding highlights
6 the importance of their continuing involvement in this area. We need to be mindful of how
7 we develop and commission advocacy services. Improving uptake of advocacy within adult
8 safeguarding should be a key priority and addressing some of the concerns raised within this
9 paper and others offers a starting point for developing this area. Demonstrating clear
10 effectiveness is vital for advocacy to cement its legitimacy and secure long term funding.
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20 In conclusion, whilst the Care Act principle of empowerment may be referring to individual
21 empowerment, political empowerment is also necessary for people to be genuinely involved
22 in “making change” (Beresford, 2016, p. 343). The increasing move towards the co-production
23 of services and recognition of participatory approaches within social policy may offer a route
24 forward in developing a more inclusive way of working. Advocacy can make a strong
25 contribution to empowerment within adult safeguarding **at both an individual level and at a**
26 **more structural level**, counteracting some of the shortcomings in provision indicated in this
27 paper. Discussions should continue around how we provide this within a climate of shrinking
28 resources.
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Renegotiating Power in Adult Safeguarding: The Role of Advocacy

Abstract

Purpose:

The increased involvement of adults at risk in the safeguarding process has become a prominent issue within English safeguarding policy. However, there is evidence to suggest that actual levels of involvement are still low. This paper presents findings from a PhD study in relation to the benefits of advocacy in supporting this involvement in adult safeguarding for older people.

Methodology:

Participants in the study included advocates and social workers who had experience of working with older people through the safeguarding process within two North East England local authorities. A critical realist approach through in-depth interviews was taken with all of the participants.

Findings:

The research findings in relation to the benefits of advocacy in supporting older people going through safeguarding processes are reported. The practical limitations and factors which help and hinder advocacy support within the process are also considered. The theoretical implications for power, empowerment and advocacy are also explored.

Research limitations:

A key limitation of this research is that it did not directly include older people who had been through safeguarding amongst the participants.

Implications:

Key implications for practice and policy are discussed.

Originality:

The paper provides an overview and critique of empowerment in adult safeguarding and the role that advocates can play in promoting this key principle.

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Value:

A key area highlighted by the research was the benefits of advocacy provision within adult safeguarding.

Keywords: advocacy, advocates, adult safeguarding, empowerment, power, older people, social work

Introduction

The involvement of adults at risk within safeguarding procedures has increasingly become a focus within English safeguarding policy since the publication of No Secrets (DH, 2000). This involvement is associated with the personalisation agenda which promotes the importance of offering service users choice and control (Carr, 2012). However, the ‘top-down’ approach of this agenda has been criticised by some for its assumption that such autonomy is equally accessible to all. Ellis & Preston-Shoot (2012, p. 168), for example, draw attention to the “controlling” of information as a “means of enacting stereotyped judgements about capacity in order to manage people’s access to direct payment”. Furthermore, those who may be structurally or systemically excluded from accessing their rights as citizens within a political climate of neoliberalism may struggle to access their rights to direct their own care and support needs (Lloyd, 2010; Stewart, 2011). Within an older population this applies particularly to those who may lack capacity to make some decisions around their care, although it may equally apply to those who do not have the confidence or the knowledge to be able to do so (Lonbay, 2015). These people in particular may benefit from advocacy support in bridging health and social care services. Advocacy at its core is about engaging with people and helping them to increase “their sense of power [...] to feel more confident, to become more assertive and gain increased choices” (Brandon et al., 1995, p.1). However, within the remit of adult safeguarding, there is some evidence to suggest that advocacy involvement is limited (Irvine et al., 2013; Manthorpe & Martineau, 2010).

Advocacy itself is contested in terms of its definition, practice, and potential for positive outcomes. Forbat & Atkinson (2005), for example, highlight the lack of consensus around both

its meaning and effectiveness. Advocacy has a tendency to be misunderstood as purely a complaints procedure or as a distinct role that professionals such as social workers can pick up in addition to their existing work (Brandon & Brandon, 2001). This potential for misunderstanding the role of advocacy has been noted by Redley et al., (2011) in relation to adult safeguarding.

There is limited research exploring the involvement of adults at risk within adult safeguarding, but where research has considered this area there is consensus that levels of involvement are low (Corkhill & Walker, 2010; Jeary, 2004; Wallcraft & Sweeney, 2011; Wallcraft, 2012). Wallcraft and Sweeney (2011, p.19) identified a number of barriers to involvement in adult safeguarding processes. These included difficulties in conceptualising risk, exclusion of some groups due to being seen as “lacking value”, and unhelpful procedures for investigating abuse. They also identified that advocacy could assist in enabling adults at risk to be involved in the process of safeguarding (Wallcraft and Sweeney, 2011; Wallcraft, 2012).

This paper presents findings from a PhD study (undertaken at Northumbria University) which explored the involvement of older people within adult safeguarding. Older people were the focus of this research because they are highly represented within adult abuse and neglect prevalence figures (NHS Information Centre, 2014) and to reduce the remit of the research in order to allow for a more in depth exploration. This paper is specifically concerned with the ways in which advocates help facilitate the involvement of older people within adult safeguarding, as well highlighting factors which either support or inhibit their work.

Policy Framework and Advocacy Provision

The Care Act (2014) replaced previous adult safeguarding policy and placed this area of work on a statutory footing. The Care and Support Statutory Guidance (CSSG) (DH, 2014) which accompanied the legislation defines adult safeguarding as:

Protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate,

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3 having regard to their views, wishes, feelings and beliefs in deciding on any
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5 action
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7 (DH 2014, p.1)
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11 Adult safeguarding is primarily located within the interpersonal dynamics between the abuser
12 and the perpetrator. As such it fails to acknowledge wider societal and structural factors which
13 have been identified by older people as being abusive (O’Brien et al., 2011; WHO/INPEA, 2002).
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15 Within the research conducted by O’Brien et al. (2011) and WHO/INPEA (2002) the erosion of
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17 personhood was also identified by older people as being abusive. This suggests that failing to
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19 involve older people within adult safeguarding processes can be perceived by them as abusive
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21 in itself. Sherwood-Johnson et al. (2013, p.117) also concluded that adult safeguarding “itself
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23 might undermine an adult’s strengths, skills and sense of self, depending on the way it is
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25 performed”. This underscores the need for effective processes which are person centred and
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27 allow the individual to make choices and have control over decision making. This is needed
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29 both within individual safeguarding procedures, as well as at a more strategic level so that
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31 older people’s voices are reflected within policy development in this area.
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35 Adults at risk are described within adult safeguarding policy as those who are “unable to
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37 protect [themselves] against [...] abuse or neglect or the risk of it” as a result of their “needs
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39 for care and support” (Care Act 2014, Section 42). However, this construction of vulnerable
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41 adults identifies this group on the basis of individual, inherent characteristics, rather than
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43 considering wider contextual and structural factors. Vulnerability here becomes a permanent
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45 aspect of identity rather than a temporary situational effect. The final aspect of the definition,
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47 that the individual is “unable” to protect themselves, also places emphasis for protecting and
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49 preventing abuse on the local authority, potentially removing the individual’s agency within
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51 responses to adult safeguarding concerns. This raises questions about how the independence
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53 of the individual is respected within adult safeguarding processes.
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56 The Care Act (2014) also incorporates six key principles:

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58 1. Empowerment – Personalisation and the presumption of person-led decisions and
59 informed consent.
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61 2. Prevention – It is better to take action before harm occurs.

3. Proportionality – Proportionate and least intrusive response appropriate to the risk presented.
4. Protection – Support and representation for those in greatest need.
5. Partnership – Local solutions through services working with their communities. Communities having a part to play in preventing, detecting and reporting neglect and abuse.
6. Accountability – Accountability and transparency in delivering safeguarding.

(DH, 2014)

Safeguarding is, in reflection of these principles, comparable to advocacy as it shifts its practice from a process led approach to a more person centered approach, which focuses on the adult at risk's desired outcomes. This approach was strongly influenced by the 'Making Safeguarding Personal' (MSP) work that has been incorporated into the CSSG (DH, 2014). The MSP guidance states the need to review how advocacy is provisioned within adult safeguarding, as well as highlighting the usefulness of advocacy in "situations where people have capacity as well as where they lack capacity" (Lawson et al. 2014, p.11). Other key principles and values associated with advocacy include 'putting people first' and 'independence' (Action for Advocacy, 2006). Furthermore, the benefits of advocacy include offering practical support, promoting empowerment, promoting social networks, and relationship building (Stewart & MacIntyre, 2013).

Advocacy support can be provisioned under the Mental Capacity Act (2005). This statute gives a power to local authorities to appoint an Independent Mental Capacity Advocate (IMCA) in cases where the person lacks capacity to make key decisions (regardless of whether there is a family member or friend supporting them). However, research which has examined IMCA provision within adult safeguarding processes has found that it is often limited (Irvine et al., 2013). In 2013/2014 there were a reported 88,260 safeguarding referrals concluded, of which 28% lacked capacity (around 24,000 referrals which could have qualified for IMCA provision) (DH, 2015). Of these only 1,730 IMCA referrals were actually made (around 7% of the cases) and the conclusion was drawn that the underuse of IMCA support within adult safeguarding is a "cause for concern" (DH 2015, p.26).

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Alongside the role of IMCAs, there is also a role for other types of advocacy, for example, Independent Mental Health Advocates (IMHAs) [whose provision is a statutory requirement for those detained under the Mental Health Act (2007)] may be involved in adult safeguarding enquiries. Case advocates can also be involved on a short term basis to support the person through the process. General, or case, advocates may also be more readily accessible due to more open referral systems and may work more holistically than IMCAs as a result of the wider scope of their role (Gorczyńska & Thompson, 2007). There is limited research which considers the roles of these types of advocacy within adult safeguarding, despite the benefits that advocacy may bring to those who have capacity, as well as those who lack capacity.

The Care Act (2014) also makes specific reference to advocacy support, presenting independent advocacy as a statutory requirement “for the purpose of facilitating involvement in the enquiry or review” (Section 68). Advocacy provision under the Care Act (2014) only comes into force if there is no other “appropriate person” to support the individual, or if the person has “substantial difficulty” in retaining/considering relevant information or communicating their views. As such, it is not clear whether advocacy provision will increase with the implementation of the Care Act (2014). The (CSSG) (DH, 2014 p. 934) also states that “The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the local authority and other organisations”. The desire for people to receive “seamless advocacy” services is also referred to, as well as the need for people to “not have to repeat their stories to different advocates” representing the Care and/or Mental Capacity Acts (p.94).

Advocates, according to the CSSG (2014, p.102), must have suitable experience, appropriate training, competence, good character, work independently (from the local authority) and engage in regular supervision. Barnes et al. (2002, p.2) write “The service must be **independent** and therefore free from conflicts of interest. This has implications for the way advocacy is provided and it is proposed that over time, advocacy moves away from provision by agencies which provide other health and social care mental health services”. However, advocacy continues to be commissioned by the local authority and therefore there is an argument to be made that it cannot be truly independent.

The Care Act (2014) highlights the importance of empowerment and placing the individual at the centre of adult safeguarding processes and associated decision making. There is an established need for this focus with evidence (gathered prior to the implementation of the Care Act) suggesting that older people are often not involved within adult safeguarding processes (Wallcraft & Sweeney, 2011). Empowerment is, however, challenging to put into practice; philosophically it's not something a social worker can 'do' to someone. Additionally, many have cited the difficulty of promoting empowerment alongside duties to manage risk and meet organisational needs (Lonbay, 2015, Wallcraft and Sweeney, 2011, Yoeli et al., 2016). The concept of empowerment itself is problematic. Whilst it is typically seen as being associated with sharing or handing over power, this in turn is difficult to align with modern social work practice. For example, it has been reported that social workers feel a sense of "powerlessness" within an increasingly privatised welfare system which promotes the "deprofessionalisation of social work" (Ferguson, 2007, p. 401). Such privatisation positions involvement as consumer choice and control, rather than aligning with the more democratic (and less individualistic) conception which has been propounded by service user groups. Advocacy at its core is in the business of empowerment, aiming to present the person's needs, wants and wishes over those of professionals. As such, there is a need to explore further the benefits of advocacy in meeting the key principles of the Care Act.

Over the past few years the profile of advocacy has been raised, but there is scarce evidence to support its effectiveness (Macadam, Watts, & Greig, 2013). Given the new statutory duty to appoint advocates under the Care Act, it is important to consider the evidence around advocacy provision within adult safeguarding.

Method

A critical realist approach allowed for an in depth exploration of advocacy and adult safeguarding by moving away from the subjectification of "the impact of the 'real' social world" (Houston 2001, p.858). Critical realism has an emancipatory approach as it seeks to expose and explore social injustice (Bhaskar, 1979, 1989). As such it was felt to be a suitable framework for this research. Ontologically, critical realism holds that there is an objective reality which is stratified, existing on three levels. These are the 'real' (generative mechanisms or structures which are not observable, but which are responsible for what we observe), the

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‘actual’ (events to which these mechanisms give rise), and the ‘empirical’ (events which are actually observed). These mechanisms are not considered to operate in a simple cause and effect relationship, but rather they are contextually contingent and research underpinned by critical realism seeks to uncover and understand these mechanisms.

Epistemologically, critical realism positions itself as interpretive; our understanding of reality is ‘concept dependent’ (Bhaskar, 1979, 1985). However, Bhaskar argues that although social products are concept dependent, they always have a “material dimension” (Bhaskar, 1989, p. 4). Critical realism would therefore acknowledge the reality of abuse, but still understand that our responses to it are social constructed. Nevertheless, these constructions have a real impact; the way in which we create and construct adult safeguarding is not arbitrary; “these structures may be socially constructed but they are nevertheless real and have power causal effects” (Elder-Vass, 2012, p. 74).

Research underpinned by critical realism therefore seeks to uncover and understand these mechanisms. Within this acknowledgement of the complex interplay between different causal powers (mechanisms) the focus is not on the search for certainties, but to “construct explanations” which may then be tested (Bhaskar, 1989, p. 69). As such, a retroductive methodology was considered to be an appropriate approach for this study. Retroduction involves moving away from the observation of events to a “conceptualisation of transfactual conditions” (Danermark et al., 2002, p. 96). Retroduction is about searching for a causal explanation for the phenomenon, although such explanations are always contextually contingent (Danermark et al., 2002).

Sampling

Two advocacy services were involved in the research as well as social workers who were employed within two English local authorities. In total, six advocates and eight social workers were interviewed. Two of the advocates interviewed were IMCAs and the others were involved in safeguarding either as IMHAs or as general/case advocates. All of the advocates had experience of supporting older people within adult safeguarding processes and the social workers interviewed all had experience of carrying out safeguarding investigations with older people. For the purposes of the research ‘older people’ were identified as those over the age

of 65. This was in line with the definition of older people used within the two local authorities under study in the research.

Data collection and analysis

Blom and Morén (2011) describe mechanisms as “analytical constructs” which are causes, motives and choices influencing observable events (Blom and Morén, 2011, p. 60). Bhaskar (1986) has also argued that reasons are causal and therefore the starting point for understanding human behaviour is the explanations that people themselves give. As such a core element of the research was key stakeholders’ accounts; interviews were used as the primary source of data collection. In depth interviews were conducted with all participants and lasted on average 57 minutes. Interviews were semi-structured which allowed the researcher to ensure that the same topics were covered with each interviewee, but also encouraged other topics to be raised and explored.

Thematic analysis was used to analyse the data. The 6 phase guide to conducting thematic analysis, as outlined by Braun & Clarke (2006) was used. This method involves six stages: familiarisation with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes and; interpretation (Braun & Clarke, 2006). The process of interpretation requires a move from descriptive accounts of the patterns found within the data to a consideration of what accounts for them. Braun and Clarke (2006) suggest that this involves going “beyond the ‘surface’ of the data” and asking questions such as “what is the overall story the different themes reveal about the topic?” (Braun and Clarke, 2006, p. 94). This fits with the overall aim of retrodution which questions why observed events occur in the manner that they do (Danermark et al., 2002).

Ethical considerations

Ethics were considered within the same framework as those for general social work practice. As such the key principles of ‘respect for autonomy’, ‘beneficence’, ‘non maleficence’ and ‘social justice’ were encompassed within the research design, process, and within dissemination of research findings (Butler, 2002). Full ethical approval was obtained for the research from the Department of Social Work and Community’s ethics committee (Northumbria University). All participants gave informed consent before they became

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involved in the research project. To ensure anonymity every participant was assigned a pseudonym and these are used within the current paper.

Limitations of the research

A key limitation of this research is that it did not directly include the voices of older people who had been through safeguarding. They were initially included within the remit of the research, however, a number of challenges were encountered when trying to recruit older people to be a part of the research and ultimately it was not possible to include their voices within the study (Lonbay, 2015).

Findings

This section presents a brief overview of the wider PhD study findings, before exploring in further detail the key findings related to advocacy provision within adult safeguarding. Two wider key themes were related to older people’s involvement within adult safeguarding. These were “older people as unable to be involved” and “older people as unwilling to be involved”. The first of these themes reflected participants’ accounts of how older people are often unable to be involved in adult safeguarding as a result of both individual characteristics (such as capacity issues) and because of the inaccessibility of the process (for example, issues with the accessibility of meetings and key information about the safeguarding process). The second wider key theme, “older people as unwilling to be involved” reflected participants’ accounts of how older people, who had capacity, could choose not to be involved in adult safeguarding. This choice could be limited by other factors, such as potentially finding the process intimidating, concerns about potential outcomes of adult safeguarding, and whether or not they agreed with professionals about the level of risk that they faced. It was also highlighted that this choice may be limited by professionals themselves. For example, in some cases concerns about risk management, or the individual worker’s willingness to involve the older person were reported as reducing the older person’s ability to make an informed choice about their involvement. Another key finding, as reported by participants, was that levels of involvement for older people were low. These two wider key themes were identified as the core reasons why this might be the case. In light of these findings, the data gathered for the PhD study was reviewed and key factors related to advocacy support were examined in further detail. These findings are the focus of the rest of this paper and are presented below.

Advocacy support.

Advocates were involved in cases where the person had no other representative. A strong theme that was identified was the role that advocates play in keeping the process person centred:

'And so our role is to try not to be their powerful advocate but to try and present them as, as they really should be presented. It's who they are as an individual. So when the safeguarding team consider the options they are not just thinking of solving the problem, they are actually considering the individual and that is how I think we can become quite powerful'

(Brian, advocate)

Overall there were three key themes related to advocacy provision: supporting the individual; making challenges and independent representation. Additionally, some elements which limited the effectiveness of advocacy were also reported. These findings are presented below.

Independent Representation.

Social worker participants identified that often it was not possible to involve older people directly within the safeguarding process due to issues with capacity, physical mobility, and where older people articulated that they did not want to attend meetings. In these cases, family members often represented them. Where family members were involved it was identified that there could be potential issues, for example, conflict between family members or where family members were representing their own views and wishes, rather than those of the older person. Independent advocates were identified as a useful way of ensuring that the process stayed focused on the older person's views, rather than on those of their family member. Where older people were not able or did not want to contribute directly advocates could be involved as a way of ensuring the individual's views and wishes were still represented:

'And some people like you to represent them entirely. And we will do that. Or you might represent somebody because they can't be there. So that's important because you are reporting back for them.'

(Sheila, advocate)

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Within this role, the independence of the advocate, as someone who was there to “*help people get their views heard*”, “*to help them get the information for them to make their decisions*” and to “*go along as a representative*” was highlighted. In one advocate’s words “*...my own personal views are totally irrelevant. It’s the views of the person*” (Ken, advocate).

Supporting the person

Advocates identified that they would spend time with the person to get to know what their views and wishes were before presenting these within safeguarding meetings. A key aspect of advocacy in the safeguarding process was the support that they could provide to the older person which included practical support in understanding the process, building confidence so that the person could self-advocate, and assisting with communication.

Whilst social workers involved in the process indicated that a core part of safeguarding was taking the time to explain things to the older person, often the tight time frames associated with adult safeguarding processes and heavy case-loads made this difficult. The benefits of advocacy in overcoming this barrier were related to their ability to spend time with the person before, during, and after meetings to help explain the process. Their experience in being involved in safeguarding meant that they were able to draw on this to enable the individual to better understand the process. Helping the older person by disseminating “*quite a lot of detailed information and [putting] that in a way that is more appropriate for the individual that they support*” was also a clear benefit of advocacy (Hugo, advocate).

This was also related to the use of jargon within meetings. Whilst social workers interviewed indicated that they always tried to avoid the use of jargon it was identified that often professionals “*fall back into jargon and it can become quite complicated for other people to understand what they’re talking about*” (Brenda, social worker). Advocates saw an element of their role as being “*to say this is what that means*” (Ken, advocate) and to ensure that “*questions are put in an understandable and a respectful way to the person ... so that the process can move forward*” (Hugo, advocate).

Another key benefit was that advocates were able to assist people to self-advocate, for example, by boosting confidence and “*supporting the service user to express their views*”

(Norman, social worker). Advocacy support was identified as useful even when there were family members available to support the individual:

'So it would be easier in some ways for them to talk to the professionals because they don't have the same relationship with them as they obviously do with their families.'

(Hugo, advocate)

Making challenges

Capacity assessments are often a core part of the safeguarding process in judging an individual's ability to be involved in the process and related decision making. Involving advocates, especially IMCAs, in the safeguarding process meant that there was a safety net for older people in relation to capacity assessments. For example, if the advocate felt that the capacity assessment had not been carried out correctly then they could *"ask and we can get them to check and see what we think"* (Brian, advocate). Advocates could also challenge within the process if they felt that decisions were made that the individual could make themselves or where delaying a decision might mean that the older person would have the capacity to make it themselves:

'We might be saying, well can we put things off...and then we can make that decision about safeguarding and it might be yes, maybe, or not so there's a bit of debate. There are kinds of questions around questions sometimes which people can get involved with.'

(Brian, advocate)

The role of advocacy was also related to ensuring that adult safeguarding measures were *"not too restrictive, that they gave the least restrictive option"* (Sheila, advocate).

Factors which influence the effectiveness of advocacy

Findings also related to factors which limited the effectiveness of advocacy. Key limitations were resources and relationships.

Relationships

Personal relationships between advocates, service users and social workers were identified as an important factor in the effectiveness of advocacy in adult safeguarding. Relationships were identified as sometimes problematic where advocates felt that other professionals involved in safeguarding did not fully “embrace” or understand the role of advocacy in adult safeguarding:

*“it’s making sure that everybody knows that you actually do have a role...
But, there are some people who never have anything to do with advocates,
and I’m talking about professionals, and sometimes that can be [...] hard
work”*
(Ken, advocate).

It was identified that developing effective working relationships between professionals could assist with this.

Resources

Another challenge was related to resources; time and money. For example, as identified above, a key benefit of advocacy was their ability to get to know the individual and present their views and wishes. Advocates indicated that this process took time but that on occasions where they were informed about safeguarding that this happened “last thing” which made it “very difficult for effective advocacy to take place” (Hugo, advocate).

Not being given the resources that they needed was also sometimes an issue, for example, not being given minutes of meetings, or having heavy caseloads which meant that their services were “stretched” (Hugo, advocate). This was impacted upon by cutting of national advocacy resources which was identified as an “issue on a bigger scale” and which meant that “it’s difficult to find funding for the training now” (Brian, advocate).

Such resource issues impact on the rates of referrals to advocacy and advocates within this research identified that there were “quite a few safeguarding alerts where we are not getting informed or involved”, even though they were aware of the high volume of cases occurring which they may have assisted with (Barbara, advocate).

The key contributions of advocacy, as reported within this paper, have been echoed elsewhere. For example, Sherwood-Johnson (2016), Redley et al (2011) and Irvine et al. (2013) have all highlighted the role that advocacy can play in complimenting adult safeguarding work. However, these authors also drew attention to existing barriers in achieving this. These include low referral rates and issues around understanding the role of advocacy within adult safeguarding. Redley et al. (2011) also found that that teams did not have a comprehensive understanding of the role of an IMCA and described having to “instruct such teams in their duties under the MCA” (p. 1063). Butler & Manthorpe (2016) also identified “limited awareness about the remit of advocacy services” as an issue which emerged within the MSP pilot.

Other research has also highlighted a perceived lack of understanding of the role of IMCAs within adult safeguarding (Irvine et al., 2013), as well as the need for greater provision of advocacy (Irvine et al., 2013; Manthorpe & Martineau, 2010). Within Irvine et al.’s work, this was associated with a perception that the process of involving IMCAs was “complex and created additional work” (2013, p. 4). Despite the issues identified above, the report also acknowledged that many improvements had already been made, for example, training and awareness raising that had taken place and the development of a more accessible IMCA referral form.

Discussion

It has previously been concluded that older people need to regain a position of independence in order to avoid adult safeguarding being driven solely by a professional interpretation of their needs (Harbison & Morrow, 1998). Whilst it is important to recognise the reality of the circumstances of many of those who become involved in adult safeguarding, there is a danger inherent in assuming a lack of ability to be involved and the associated focus with utilising family members as the sole representative of the person within the safeguarding process, rather than drawing on advocacy support. The advantages of advocacy in these cases have been outlined above and it is clear that the provision of advocacy within adult safeguarding

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can make a contribution towards empowerment and proportionality under the Care Act (2014).

However, for advocacy to be effective there is a need to consider some of the limitations that this paper has highlighted. These include the way in which advocacy is commissioned and provisioned, the interpersonal relationships between advocates and other professionals, and the way in which empowerment is framed within policy and practice. These are discussed below.

The Provision of Advocacy

There is a need, firstly, to further investigate the way in which advocacy is provisioned. The findings that advocates feel they are often left out of adult safeguarding processes, or that they are contacted at the last minute, has a definitive impact on the contribution that they are able to offer. Issues around the tight time frames for responding to abuse may contribute to this occurring and there is a clear need for greater flexibility within the process (Lonbay, 2015). Again, this was found in Sherwood-Johnson’s work; “the findings with respect to late referrals raise the question as to whether an appropriate balance is being struck between procedures to ensure timeliness, on the one hand, and flexibility to foster person-centred practice including the involvement of advocacy, on the other” (2016, p. 117).

Sherwood-Johnson (2016) also highlighted that the experience in England, where there is an attempt to align personalisation and adult safeguarding, could help to inform this debate in Scotland. The findings from this research, however, suggest that this is an issue that is also being experienced within England and that it warrants further attention and consideration. It may be that with the recently shifting practice guidelines under the Care Act (which suggest that a greater degree of flexibility may be possible in relation to safeguarding enquiries) these issues may become less common. However, at this stage it is difficult to foresee what concrete changes will occur in relation to late referrals.

The Commissioning of Advocacy

Secondly, issues with the availability of advocacy have been raised. The way in which advocacy is commissioned is therefore an important area to consider. The Care Act highlights the need to ensure choice and focus on wellbeing when commissioning services. Additionally, SCIE guidance (SCIE 2015, p.21) highlights the importance of using “evidence about what works” when commissioning services, further emphasising the need for research which explores the role of advocacy within adult safeguarding and provides evidence for the benefits of advocacy provision within adult safeguarding. However, issues with the commissioning of advocacy services have been cited. For example, True Voice, an organisation which aims to “make rights a reality”, carried out a scoping exercise around Care Act advocacy provision with the results published in 2015. Of 34 organisations who responded, none believed that there was a “clear and realistic link” between the proposed funding and projected uptake for advocacy services. Furthermore, only one in nine respondents believed that funding would be sufficient to ensure adequate access to advocacy provision under the Care Act (True Voice, 2015).

Issues with funding may lie at the heart of advocacy provision, with local authorities forced to make difficult decisions around allocation of funds. Projected costs for advocacy provision in 2015/16 were estimated at £16m, although it was considered that this could rise to £24.5m by 2024/25, due to potential increases in previously unreported cases (DH, 2014). Evidence has suggested the potential for advocacy to offset these costs; “early findings indicate that for every £1 invested in older people’s advocacy, a social return investment of £8.00 is returned” (DH, 2014, p. 76). This suggests that in addition to the benefits of advocacy highlighted by this article and others, there is a “monetary value” attached to “increased advocacy service” (DH, 2014, p. 76).

Relationships

Thirdly, there is a need to consider the ways in which social workers and other agencies work alongside advocacy services and how these relationships are developed. The participants in this research indicated that developing relationships with individuals promoted their involvement within adult safeguarding cases. Given the multi-agency emphasis within adult

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safeguarding, development of such relationships should be a key priority. These can be fostered by the inclusion of advocacy services on SABs (an arrangement which currently exists in many local authorities). Relationship building of this type may also serve to respond to the findings from this research that advocacy provision can be hampered by attitudes and understanding about the role that advocates can play within adult safeguarding. This was also an issue raised within the Scottish context, as reported by Sherwood-Johnson (2016). SCIE guidance on the implications of personalisation for advocates (SCIE, 2009) states that advocacy means “working alongside people who use services to ensure that there is a genuine shift in control and decision making in their favour” (SCIE, 2009, p.1). However, as previously mentioned, this focus on shifting power from professionals to service users can be problematic. A more nuanced understanding of power and advocacy, discussed below, may help to shift the balance still further, for example, by expanding the remit of involvement and enabling older people to have greater choice and control over the way in which adult safeguarding policy is developed and implemented.

Power and Empowerment

Finally, there is a need to consider and debate the concept of ‘empowerment’, and how it is understood and applied in practice and policy. The findings from this study and others suggest that older people are often not engaged within adult safeguarding processes. Whilst attempts are made to “hear the voice” of the person, arguably this not a truly empowering experience for them (Lonbay, 2015). This paper has highlighted the role that advocates can play in adult safeguarding including supporting the person, providing independent representation, and making challenges within the process. Overall, these findings suggest that advocates can and do assist in meeting the key principle of the Care Act (2014) in relation to ‘empowerment’ by ensuring that the voice of the person is recognised and adhered to within decision making.

As Cambridge & Parkes (2004, p.724) argued, advocacy input into adult safeguarding can be helpful in shifting “the balance of power in decision-making towards the service users and away from professional interests”. Such a shift in power is a requirement in order to avoid perpetuating the paternalistic elements of adult safeguarding which have long been the

subject of criticism (e.g. Humphries 2011). Advocacy at its core is in the business of empowerment, aiming to present the person's needs, wants and wishes over those of professionals. However, as previously discussed, empowerment is not easy to achieve. The way in which advocates assist within the safeguarding process can be viewed as empowerment at an individual, or micro level. Power, in this depiction, is seen as a commodity; something which can be taken or shared. This form of power has been conceptualised as the dimension of 'visible power' by Lukes (1974) and Gaventa (2006), whereby there are winners and losers in the struggle for power. In this case, it can be linked to the advocates role in making challenges within the process and ensuring that older people do not 'lose' within the safeguarding process, for example, by making sure that their views and wishes are respected and adhered to. On the surface then, the advocates role in 'empowerment' can be viewed as an exercise in control over decision making which is reflected in the definition of advocacy given by SCIE that advocacy means "working alongside people who use services to ensure that there is a genuine shift of control and decision making in their favour" (SCIE, 2009, p.1).

A second dimension of power, suggested by Lukes, is that power can also operate to control who gets a seat at the decision making table. This in turn can be seen within the guidance for adult safeguarding. Firstly, in relation to the increased focus of involvement for adults at risk and for advocates; these spaces are now more open for both advocates and for older people. As such, in this sense adult safeguarding can be viewed as more 'empowering' for both older people and for advocates. Advocates in turn may have a greater scope to fulfil an empowering role within the process under this new guidance (as demonstrated by the findings from this paper and others). In reflection of these two dimensions of power it could be argued that advocates can and do ensure that the principle of empowerment is upheld within adult safeguarding processes. However, this depends on an understanding of power that is located within interpersonal dynamics. This ignores the diverse ways in which power operates and the potential for empowerment to occur at a societal or political level.

A third dimension of power, proposed by Lukes, was that power operates to shape people's attitudes and perceptions in order that they come to accept social practices. This form of power is 'invisible'; it shapes our practices through our internalisation of norms and cultural

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practices (Gaventa, 2006; Lukes, 1974). This ‘invisible’ power is reflected in areas such as the attempt to align an increased focus on involvement and empowerment with the public desire to be more actively involved in dictating their health and social care needs. In the case of the Care Act, a focus on empowerment and a supposed increased utilisation of advocacy has aligned with the public desire to move away from an adult safeguarding system which the review of No Secrets suggested can protect at the expense of independence (DH, 2009). In the Care Act, for example, advocacy is only considered in relation to individual support, for when an individual has no appropriate person to support them and substantial difficulty in understanding the process. The purpose of advocacy here is to facilitate the involvement of the individual. As such, this “invisible power” shapes acceptance of what advocacy is, or can be, and when it might be useful.

It seems overall, therefore, that in relation to ‘visible’ and ‘hidden’ power, some elements may be transferred to older people (either directly or with the support of advocates). The third dimension, however, continues to reside with policy developers and implementers. Through this framework of power and empowerment, it can be seen that whilst the Care Act (2014) may prioritise empowerment, the delivery and form of this is restricted. This is not to negate the positive elements of having empowerment embedded within the legal framework for safeguarding. Individuals who access power in this way may indeed feel more in control of the safeguarding process, supported by advocacy and achieve outcomes that are more satisfactory to them. Empowerment in this form therefore has many benefits. The updated policy framework for adult safeguarding and the increased focus on outcomes and “Making Safeguarding Personal” have indeed been shown to have positive benefits for adults at risk, for example, helping the person “think about what they wanted” and enabling social workers to practice in a more “person centred” manner (Manthorpe et al., 2014, p. 100).

Lukes’ work on power, in relation to advocacy and adult safeguarding, raises the notion that for empowerment to be meaningful, consideration of these three forms of power needs to be undertaken. This involves transfer of control and resources (visible power), access to decision making spaces (hidden power), and a greater consciousness and understanding of oppression and the forms that this can take in order to facilitate a desire to challenge the shaping of norms and practices that exclude older people (invisible power). These include, for example, the ways in which adults at risk are positioned within policy, ageist attitudes and

the acknowledgement and challenging of wider societal and structural factors which older people perceive as abusive (O'Brien et al., 2011; WHO/INPEA, 2002). As previously discussed, not all people may want or have the ability to do this. Advocacy therefore should consider a role in representing and empowering people at this structural level, as well as at an individual level. This wider understanding of the role of advocacy and empowerment may be a key stepping stone towards participatory approaches to social policy, a "major attempt to enable people to speak for themselves, instead of being spoken for" (Beresford, 2016, p. 173). This would shift the focus of advocacy from being solely about the individual, to being more of a collective lobby against neoliberalism and the associated consumerist approach to involvement and empowerment.

Conclusion

Whilst there are some barriers to advocacy involvement in adult safeguarding, it is clear that they play an important role within this multi-agency area of working. In particular, their role in creating a more empowering and proportionate approach to adult safeguarding highlights the importance of their continuing involvement in this area. We need to be mindful of how we develop and commission advocacy services. Improving uptake of advocacy within adult safeguarding should be a key priority and addressing some of the concerns raised within this paper and others offers a starting point for developing this area. Demonstrating clear effectiveness is vital for advocacy to cement its legitimacy and secure long term funding.

In conclusion, whilst the Care Act principle of empowerment may be referring to individual empowerment, political empowerment is also necessary for people to be genuinely involved in "making change" (Beresford, 2016, p. 343). The increasing move towards the co-production of services and recognition of participatory approaches within social policy may offer a route forward in developing a more inclusive way of working. Advocacy can make a strong contribution to empowerment within adult safeguarding at both an individual level and at a more structural level, counteracting some of the shortcomings in provision indicated in this paper. Discussions should continue around how we provide this within a climate of shrinking resources.

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